Triage Note

* Final Report *

Result date:

28 October 2012 9:55 EDT

Result status:

Auth (Verified)

* Final Report *

ED Triage Entered On: 10/28/2012 10:00 EDT Performed On: 10/28/2012 9:55 EDT by

Assessment I

Chief Complaint: pt with treach, and hemodialysis there is no therapist where he resides. there is no care for his

treach, and he has green drainage. pt was not on 02 on ems arrival. pt had confusion and hallucinations.

IV Field Start: No

Affect/Behavior: Calm, Cooperative Pain Scale Type: 0-10 Pain scale

Primary Pain Intensity: 0 Allergies Reviewed: Yes

Temperature Tympanic: 99.1DegF(Converted to: 37.3DegC)
Peripheral Pulse Rate: 105bpm (HI)

Peripheral Pulse Rate: 105bpm (HI) Respiratory Rate: 24br/min (HI) Systolic Blood Pressure: 126mmHg Diastolic Blood Pressure: 68mmHg

SpO2: 92% (LOW)

Oxygen Flow Rate: 6L/min

Dosing Weight: 90kg(Converted to: 198lb 7oz, 198.416lb)

(R) Patient Weight: Stated

Height: 67inch(Converted to: 5ft 7inch, 170.18cm, 5.58ft)

Assessment II

Pregnancy Status: N/A Fall Risk Order Detail: No Languages: English

Dx Control/PMH

Triage Reason for Visit: Yes

Problems(Active)
Tracheostomy tube

PowerChart; Last Updated: 09/24/2012 8:10 EDT; Life Cycle Date: 09/24/2012; Life Cycle Status: Active; Vocabulary:

SNOMED CT

Diagnoses(Active)

Altered mental status

Date: 10/28/2012; Diagnosis Type: Reason For Visit;

Page 1 of 2 (Continued)

10/28/2012 9:55 EDT

10/28/2012 9:55 EDT

10/28/2012 9:55 EDT

(As Of: 10/28/2012 10:00:13 EDT)

Triage Note

* Final Report *

Confirmation: Complaint of; Clinical Dx: Altered mental status ; Classification: Present On Admission; Clinical Service: Emergency medicine; Code: SNOMED CT; Probability: 0; Diagnosis Code: 2576783013

ESI

Requires immediate life-saving interventions?: No Is this a high risk situation? Consider AVPU score.: No How many different resources are needed?: Many ESI vital sign alert: No ESI recommended level: 3 ESI clinical agreement: Yes

DCP GENERIC CODE

Tracking Specialty: Main ED

Tracking Acuity: 3
Tracking Group: ED Tracking Group

Allergy

Allergies (Active) NKA

(As Of: 10/28/2012 10:00:13 EDT)

Result date:

28 October 2012 10:57 EDT

Result status:

Auth (Verified)

medical

Patient: Age: 55 Author:

Attachments, None

Basic Information

Time seen: Date & time 10/28/2012 10:57:00

History source: Patient Arrival mode: Ambulance History limitation: None.

Additional information: Chief Complaint from Nursing Triage Note: Chief Complaint.

Chief Complaint pt with treach, and hemodialysis there is no therapist where he resides. 10/28/2012 9:55 EDT there is no care for his treach, and he has green drainage. pt was not on 02 on ems arrival, pt had confusion and

History of Present Illness

The patient presents for re-evaluation of "sent to hospital because I had a argument with a nurse". No new complaints, usually with nausea after HD, last HD yesterday. Symptoms since visit: today. Therapy today: none. Associated symptoms: none.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.

Skin symptoms: Old would pressure ulcers.

Respiratory symptoms: Negative except as documented in HPI and on vent. Has same chronic trach discharge, no change.

Cardiovascular symptoms: Negative except as documented in HPI. Gastrointestinal symptoms: Negative except as documented in HPI. Genitourinary symptoms: Negative except as documented in HPI. Neurologic symptoms: Negative except as documented in HPI.

Health Status

Allergies:

Allergic Reactions (All)

NKA

Medications: (Selected).

Prescriptions

Ambien 5 mg oral tablet: 5 mg = 1 tab, Oral, Tablet, qHS, PRN insomnia, # 10 tab, 0 Refill(s), other reason (Rx) Protonix 40 mg oral delayed release tablet: 40 mg = 1 tab, Oral, Tablet EC, qDay, # 30 tab, 0 Refill(s), other reason

Vitamin B Complex with C and Folic Acid oral tablet: 1 tab, Oral, Tablet, qDay, #30 tab, Refill(s) 0 albuterol 0.63 mg/3 mL (0.021%) inhalation solution: 0.63 mg, Nebulized, TID, #75 mL, 0 Refill(s), other reason (Rx) clotrimazole 1% topical cream: 1 app, Topical, Cream, BID, # 15 gm, Refill(s) 0, other reason (Rx) codeine-promethazine 10 mg-6.25 mg/5 ml oral syrup: 5 mL, Oral, Syrup, q6hr, PRN cough, # 60 mL, Refill(s) 0, other reason (Rx)

collagenase 250 units/g topical ointment: 1 app, Topical, Ointment, qDay, 1 gm

duloxetine 60 mg oral delayed release capsule: 60 mg = 1 cap, Oral, qDay, # 30 cap, 0 Refill(s) folic acid 1 mg oral tablet: 1 mg = 1 tab, Oral, Tablet, qDay, # 30 tab, 0 Refill(s)

heparin 5000 units/mL injectable solution: See Instructions, Heparin Sub cutaneous injections 5000 u every 8 hrs for DVT prophylaxis, # 1 app, 0 Refill(s), other reason (Rx)

lisinopril 40 mg oral tablet: 40 mg = 1 tab, Oral, Tablet, qDay, # 30 tab, 0 Refill(s)

metoproloi tartrate 25 mg oral tablet: 37.5 mg = 1.5 tab, Oral, Tablet, q12hr, # 90 tab, 0 Refill(s), other reason (Rx)

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midodrine 5 mg oral tablet: 10 mg = 2 tab, Oral, Tablet, One Time Unscheduled, PRN other- see order comments. # 60
                  tab. 0 Refill(s), other reason (Rx)
                morphine 15 mg oral tablet: 15 mg = 1 tab, Oral, Tablet, q4hr, PRN pain, # 24 tab, 0 Refill(s), other reason (Rx)
                nystatin 100,000 units/g topical powder: 1 app, Topical, Powder, Ad Lib, 1 gm, rash
                sevelamer carbonate 2.4 g oral powder for reconstitution: = 1 Pack, Oral, Injection, TID, # 90 Pack, 0 Refill(s), other
                  reason (Rx)
                tamsulosin 0.4 mg oral capsule: 0.4 mg = 1 cap, Oral, Capsule, qDay, # 30 cap, 0 Refill(s)
       Documented Medications
            Ordered
                 Cepacol Sore Throat mucous membrane lozenge: Oral, Lozenge, q2hr, PRN sore throat, Refill(s) 0
                ferrous sulfate 300 mg/5 mL (60 mg elemental iron) oral liquid: 300 mg = 5 mL, OG, Liq, TID, 0 Refill(s)
  Immunizations: Include Immunizations.
       Previous
            influenza virus vaccine, inactivated: Ad hoc dose (influInj) 10/28/2010 EDT, Ad hoc dose (influInj) 10/08/2011 EDT, Ad hoc
              dose (influenza vaccine, adult) 10/09/2012 EDT.
            pneumococcal 13-valent vaccine: Ad hoc dose () 03/20/2012 EDT.
            pneumococcal 23-valent vaccine: Ad hoc dose (Not Given) 01/20/2010 EST, Ad hoc dose () 06/30/2012 EDT.
       Future
            No future immunizations have been selected or recorded.
Past Medical/ Family/ Social History
  Problem list: Include problem list (past medical history).
       All Problems
            Tracheostomy tube / 207832018 / Confirmed
            Inactive: Acute pancreatitis / 303630010
            Inactive: Alcohol abuse / 25750014
            Inactive: Alcohol withdrawal syndrome / 294674018
            Inactive: Bleeding precautions / 50851019
            Inactive: Cardiac arrest / 2472090018
            Inactive: Cataracts / 2839686017
            Inactive: Cholecystectomy / 64698015
            Inactive: Clostridium difficile infection / 286580015
            Inactive: Colitis / 106758018
            Inactive: Contusion of hip / 74751019
            Inactive: Depression / 380529010
            Inactive: Depression / 486184015
            Inactive: Drug abuse / 44243014
            Inactive: EtOH - Alcohol / 2579708017
            Inactive: Gastritis / 7841019
            Inactive: HTN - Hypertension / 2164904016
            Inactive: Hypercholesterolemia / 23283015
            Inactive: MACULAR DEGENERATION (SENILE) OF RETINA, UNSPECIFIED / 362.50
            Inactive: Respiratory arrest / 144786014
            Inactive: Tarsal tunnel decompression / 494816014
            Inactive: Tonsillectomy / 268484012
            Resolved: Suicidal Ideation / V62.84
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Surgical history:

Tarsal tunnel (SNOMED CT 32945011) in 2008 at 51 Years.

History of knee surgery (SNOMED CT 2692296016) in 1982 at 25 Years.

Cholecystectomy (SNOMED CT 64698015)

History of tonsillectomy (SNOMED CT 2790280011).

Comments:

10/06/2011 14:50 -

1985 does know specific dates

Family history:

No family history items have been selected or recorded.

Social history: Alcohol use: Denies, Tobacco use: Denies, Drug use: Denies, Family/social situation: Nursing home resident.

Physical Examination

```
Vital Signs
Vital Signs.
       10/28/2012 9:55 EDT
                               Temperature Tympanic
                                                         99.1 DegF
                                               105 bpm HI
                      Peripheral Pulse Rate
                                             24 br/min HI
                      Respiratory Rate
                      Systolic Blood Pressure 126 mmHg
                      Diastolic Blood Pressure 68 mmHg
                      SpO<sub>2</sub>
                                        92 % LOW
Measurements.
       10/28/2012 10:35 EDT Height
                                                  67 inch
                                           Stated
                      Patient Weight
                                        2.06
                      BSA
                      Body Mass Index
                                             31 m2
                                            90 kg
                      Dosing Weight
                                                 67 inch
       10/28/2012 9:55 EDT
                              Height
                      Patient Weight
                                           Stated
                                            90 kg
                      Dosing Weight
Basic Oxygen Information.
                                                  67 inch
       10/28/2012 10:35 EDT Height
                                           Stated
                      Patient Weight
                      BSA
                                        2.06
                      Body Mass Index
                                             31 m2
                                            90 kg
                      Dosing Weight
                      Primary Pain Intensity
                                             0
                                            0-10 Pain scale
                      Pain Scale Type
                      Cardiovascular Assessment PF
                                                            Assessment norms met
                                                              Heart rhythm regular, Nail beds are pink, No
                      Cardiovascular Assessment Norms
            edema
                      Respiratory Assessment PF Exceptions noted
                                          Unlabored, Other: trach
                      Respirations
                      Respiratory Pattern
                                             Regular
                      Respiratory Pattern Description
                                                          Regular
                      Cough
                                         Occasional
                      GI Assessment PF
                                              Assessment norms met
                      Gastrointestinal Assessment Norms
                                                              Abdomen soft, nontender, nondistended,
            Bowel sounds present in all 4 quadrants, If present, stools are soft, formed, brown and within last
                                                            Exceptions noted
                      Integumentary Assessment PF
                      Skin Abnormality Present Yes
                      Incision/Wound, Ulcer, Skin Tear Present Yes
                      Surgical drains/tubes present
                                                          No
                                                           Skin Abnormality/Location Grid
                      Skin Abnormality/Location Grid
                      I/W Present on Admission-Site A
                                                            Yes
                      Site A Healed
                                           No
                      Incision/Wound Type-Site A
                                                          Traumatic wound
                                                           Other: knees
                      Incision/Wound Location-Site A
                      Feels Safe at Home?
                                              Yes
                      Depression Medical History
                                                          Yes
```

None

Medical Devices

```
Reg Cigarette Smoking Last 365 Days
                   Skin Breakdown Risk Triage
                   Tobacco Use
                                        > 1 year ago
                   ED Assessment Adult Form ED Assessment Adult Form
                   10/28/2012 9:55 EDT
                           Reg STK Adm Elective Carotid Intervent No
                   Reg VTE Surgical Patient No
                   Reg VTE ICU Surgical Patient
                                                      No
    10/28/2012 9:55 EDT
                           Reg SC Clinical Trial
                                                 No
                   Reg STK Clinical Trial No
                   Reg VTE Relevant Clinical Trial
                                                      No
                   Reg VTE Present on Arrival
                                                     No
    10/28/2012 9:55 EDT
                           Reg AMI Relevant Clinical Trial vA
                                                                No
                   Reg HF Relevant Clinical Trial
                   Reg PN Clinical Trial vA No
                                                pt with treach, and hemodialysis there is no therapist
    10/28/2012 9:55 EDT
                           Chief Complaint
         where he resides, there is no care for his treach, and he has green drainage, pt was not on 02
        on ems arrival. pt had confusion and hallucinations.
                   Height
                                    67 inch
                   Patient Weight
                                       Stated
                   Dosing Weight
                                        90 kg
                                            99.1 DegF
                   Temperature Tympanic
                   Peripheral Pulse Rate
                                           105 bpm HI
                                         24 br/min HI
                   Respiratory Rate
                   Systolic Blood Pressure 126 mmHg
                   Diastolic Blood Pressure 68 mmHg
                   SpO<sub>2</sub>
                                     92 % LOW
                   Primary Pain Intensity 0
                                        0-10 Pain scale
                   Pain Scale Type
                   Oxygen Flow Rate
                                         6 L/min
                   Pregnancy Status
                                         N/A
                                       Calm, Cooperative
                   Affect/Behavior
                   Languages
                                       English
                   IV Field Start
                                     No
                   ESI life-saving interventions needed
                   ESI high risk situation/AVPU score eval No
                   ESI resources needed
                                           Many
                   ESI vital sign alert
                                       No
                   ESI recommended level
                   ESI clinical agreement Yes
                   Tracking Group
                                        ED Tracking Group
                   Tracking Acuity
                                       3
                   Allergies Reviewed
                                         Yes
                   Fall Risk Order Detail
                                         No
                   ED Triage Form
                                         ED Triage Form
                   Triage Note
                                      ED Triage
General: No acute distress.
```

Skin: Dried healing lesions on bliateral knees, guaze in place, dried blood .

Head: Normocephalic.

Neck: Supple and Tach collar in place.

Eye: Pupils are equal, round and reactive to light and extraocular movements are intact.

Ears, nose, mouth and throat: Oral mucosa moist. Respiratory: Lungs are clear to auscultation.

Gastrointestinal: Soft, Nontender and Non distended.

Genitourinary

Neurological: No focal neurological deficit observed, normal motor observed and normal speech observed.

Medical Decision Making

Differential Diagnosis:hallucinations, Mild hypokalemia, Dehydration, PNA.
Chest X-Ray:Include Rad interp(flowsheet): Diagnostic Radiology.
10/28/2012 12:22 EDT XR Chest Portable 1 View REPORT

Reexamination/ Reevaluation

Time: 10/28/2012 12:19:00 .

Vital signs

results included from flowsheet: Vital Signs

Pain status: pain level 0 out of 10.

Notes: Nurse reporst that patient seems consued, 'asking when Linda is coming," "Can you pick up the needle off the floor because the little girl is coming".

Impression and Plan

Hypokalemia, Mild, Visual hallucinations- improved

Plan

Condition: Improved, Stable.

Disposition: Patient care transitioned to: Time: 10/28/2012 17:00:00.

after seen by BH.

Within 1-2 days See the NH Doctor tomorrow or your primary care to review your medications.

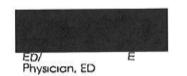
Follow up with: Counseled: Patient.

		ex AC	MISSION DATE	10-28-12
		HOME PHONE NO	MARITAL STATUS	RELIGION
	RESPONSIBLE PERSON OR AGENCY [Name and Address)		TEL	EPHONE NO
PATA		ini		
MINT		TMC	TEL	EPHONE NO
IDEN	hysician or Chrise)	TELEPH	ONE NO DAT	E OF NEXT APPOINTMENT
	2	The same submission of the same	OTH OTHER	(FD
	THE REPORT OF THE PARTY OF			
	Ox: Rhabdonyolysis Leading to C-Diff-Tracheostomy-GA	Ronal Freile	re ESK	7
,	0- Nift - Tenahenstomy-Gh	ube-Mastor	11415 - SE	2035
	1)0000055100		11	Preceno Popla
	Diet: Renal diet + Jevity 1.0 29 * May have meds no or Dia C Bolus & 1500 Hzo Every 8 hrs	bec bolus a. l.	Don la	webc 10/9/12
	LANAU house mande on or DIA	Stube	, ,	acres 1410
	BOLUS & 150 CE HED EVERY 8hrs	to Keep Gtalos	e parent	- 04
NO	Dialysis@ some	Hto ?	Tues-The	ers -Sat
DRMAT	Tx to Zago Coleium Akg	- 140	12	12 ¥
RE INFO	Meds: (aont)	" Con	EUDOD X	2 days
NI CA	LisinopRil 40ym PO@94	Halle	chodin	29
PATI	Multi Vit ZBC & Holic Haid@94	Oz So	et 95%	0
	Pantoprazole Longu PO @ 9A	082	14-22	186/104
	Metopolol 37 Sugar PO EVERY /X	111/	,	
	Morphine 15 mgm Every 4hrs P	077 778	1-22/2	
AND	•	Crx	at 94%	0
`	MEDICATIONS FREQUENCY LAST GIVEN	MEDICATIONS (Drug, Strongth, Mode)	FREQUENCY	LAST GIVEN
	· Heparin 5000 units Q 8hrs 5/2 24	Albutenex Inh Tx	- 3xday	
	5 Tamoutoin Ortuna Q hedrone Ox	Jun both 60 and	00 0 90	
5	7 Folic Acid Imply (a) 9A DIAGNOSIS GIVEN	EXPLAINED TO LOUPE PROGN	OSIS GA	LAINED TO
ORDERS	THERAPEUTIC GOALS	Patient Family		Patient Family
	"Full Code"		(specify)	
	PATIENT SERV START SERVICES REQUESTED Occ Speech Phys.	apy H H Social work	Other	
	IS TREATMENT FOR CONDITION FOR WHICH PATIENT WAS HOSPITALIZED (If NO explain) Yas No		PATIENT ESSENT	No No
	I HEREBY CERTIFY THAT THE ABOVE SERVICES SHOULD BE PROVIDED BY Acute Hosp Chronic Hosp NF Home Hoolth Agy	Robab Contor		DATE SIGNED
**	the same of the sa	2 (S. L. J.		

	a Contraction
ED/	E
Physician, ED	

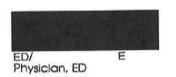
M

Current Psych Treatme	ent 💢 NO	O YES	Provider			
Last Appointmentif no, explain		Next Ap	pointment	Contacted	DYES	ON (C)
Source of information	X Self (⊃ Family	Medical Record	Other		
HISTORY OF PRESENT Chief Complaint (Patient	T ILLNESS (HPI)	Mon di diy	current status, stressors ar	nd events leading up to this	assessme	nt)
from his past ou	also reetite, visiced the ostomy turns on due to ina cubic to aure barrentaking a cubic there. Phorestonics such constructions are cubic there is a cubic there	posts of his since and post of the post of	as had tingon motorcyce cich ssible paralysic cure for himself fagain. Pf. da n forsleap. Pf. 18 10 seconds se vith have bee fe about 8 wee fe about 8 wee fe about 8 wee	fusion/VH. Ptolent 8/2012 the soft arms and recting to messing the says he will so worth he looks on to past well kis ago when attempts through the looks of when the looks after the looks of the looks	repor at lef lirgs. out do e peop s back s, bu vestur of nas	ts Pt at olc and that dese
☐ Family / Significant of	her report (see b	elow)	☐ No Family / Others	available to report		
☐ Patient refuses to allo	w contact with fa	mily / others				
Renal Failure and	ondialysis.					
History of Med	Noncompliance	🗅 Trea	ment Noncompliance	Describe		
SIGNATURE/DEGREE/	TITLE .		DATE	ЕЛІМЕ <u>10/08/12- (</u>	o 15p	w



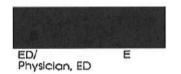


MEDICAL HISTORY Medication or other Allergie	s Do Knour	Allegics			
Primary Care Doctor					
Current Medical Problems LINION TO MOVE OF CHARLES OF C	rms and least neul hypoghten of Tested Xi Not	or give details O MOTOLO NO ESRF applicable	Tracheas Jule accident	obgyn_	hypoKalonia, , trrv, hyporlipidomia,
Are you currently experiencing		C YES	M NO	☐ Acute	
Have you had pain in the last	several weeks?	C YES	Жио		
If yes, discuss with MD and d	ocument discussion	on and name of	MD		
Past Medical Problems OCCIONNO Surgeries TUSAI Hung				Marie Control Ma	
Psychiatric Medications SCC 0HQCN(d)	Dosage	Frequenc	У	Last Taken	Prescribing MD
Other Medications	Dosage	Frequenc		Last Taken	Prescribing MD
Previous Psychiatric Medicati	ons 🗅 NO	or UNKNOW	un ~Cym	batta,lex	apo, Rement
SIGNATURE/DEGREE/TITLE				. DATE/TIME	10/08/10 5.40000 Page 3 of 17



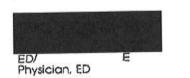


	eychiatric Treatment nt or Where				Reason			Dates of Treatment	
Outpatient					, , , ,				
18	P8			21			12/8/11/	0 12/13/11 300)	
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Substance He	se/Addictions								
Substance Os	Date of	Age of	Duration	Intensity	Patterns of	Conse	quences	Use by Family	
Odbstarioe	Last Use	onset	(Y/M)		Use		Use	Members	
Alcohol	TEFORC 8	1301300							
Cocaine	POS	-							
Manjuana	45-10-0								
Opiates/Heroir	bunkan	Wina or	rocts/0x	godone	1445 - 155-151				
Hallucinogen	Decies								
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Other	V			17/2 5 - 13					
Gambling Beh Past Substan	navior X NO	O or give de		revious tre	atment)				
Inpatient or	Where		Reason	D	ates of		rious	Response to	
Outpatient				Tre	eatment	Medic	ations	Treatment	
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Medical Proble	ems Associated	with Drug	Use/Withdraw	val O NO	☐ Seizures	ΦD.	i's 🗆 Oth	ner Blackout	
mild_	(habdomy01	USID D	12 10/10.	tollio					
	2011.90	9							





FAMILY HIST	ORY				
Psychiatric his	tory 🗅 NO or desc	cribe Parents-ETOH	, Bro-2701	1	
Living situation With Support Syste.	Alone Spo m (List family m K relics on Shis family Via	ORY actured facility © Hotel buse/Sig Other embers, names and ages Sign for his	□ Family s, case workers p. Hc has	two 5005	Ճ Other <u>PCO/S</u> s, etc)
	ghest level achieved) _z	esmintes	NA SOLETING		
Veteran	D NO D YE				
Occupation	☐ Unemployed		memaker Dith <i>Chun</i> u	Retired	Disabled
AN ADDRESS OF THE PROPERTY OF	DATE OF THE PARTY				
History of abu	ise:	Abuses			Abunad
Phy	sical Abuse	Abuser		Atage	Abused
26 1388 TV	AND THE PROPERTY OF THE PROPER	Victim		By whom	
Se	xual Abuse	When •		At age	70
Emo	tional Abuse	Victim		By whom At age	
		Victim		By whom	
Has this been	, ,,	/	To whom _		
Emotional/Phy	sical effects of Abuse _	9			
Sexuality	Heterosexual Single Partner	☐ Homosexual ☐ Multiple Partners	☐ Bisexual ☐ High Risk	☐ Active Behavior	☐ Inactive
Legal History	□ NO or give	details <u>DUI X</u> 2			
	DEGREE/TITLE			DATE/TIMI	
CN9199					Page 5 of 17





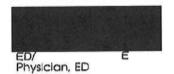
SINGLE PATIENT ASSESSMENT OF DATA BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

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SUICIDE RISK ASSESSMENT

CN9199

Risk Factors
Suicidal behavior Denies all (be as specific as possible, must comment if box is checked) Suicide attempt within the last 24 hrs History of prior suicide attempt Aborted suicide attempt Self injurious behavior Comment 19/2011 and 10/2010 overdose, hx threatening Slumbgum, hx dislocating profuse lines in basement
Current/past psychiatric or medical disorders
Key symptoms Denies all Anhedonia
Family History Attempts and/or completed suicide by family members Yes No Comment
Precipitants/stressors/interpersonal (real or anticipated)
Change in treatment ☐ Discharge from psychiatric hospital ☐ Change in provider ☐ Change in treatment Comment
Access to firearms SNATURE/DEGREE/TITLE DATE/TIME 10/28/12 Lipnur





SINGLE PATIENT ASSESSMENT OF DATA BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

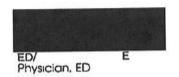
SUICIDE RISK ASSESSMENT (continued) 2. Protective Factors Responsibility to children/pets Social support Ability to cope with stress ☐ Religious beliefs □ Positive theraputic relationships Frustration tolerence ☐ Other 3. Suicide Inquiry a Ideation ☐ Never 🂢 Rarely ☐ Sometimes ☐ Frequently □ Constantly Frequency Brief/fleeting ☐ Focused/deliberation ☐ Other Intensity ☐ Past 48 hours ☐ Past month □ Continuously Duration X No ☐ Yes b Plan (If yes must comment) What Donies Stintentiplan When Where What has been done to prepare for this c Behaviors Past attempts Aborted attempts Rehearsals Non-suicidal self-injurious actions ☐ None d Intent 4 Suicide Risk Level X Low ☐ Moderate ☐ High 5. Intervention MD/APRN notified of risk level ☐ PHP □ IOP ☐ Outpatient Referral Consider ☐ Inpatient referral ☐ Constant Visual Observation ☐ Constant Close Observation 5 minute checks Other

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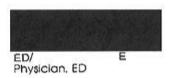


SINGLE PATIENT ASSESSMENT OF DATA BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

DATE/TIME 1928/12 60M)

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		677	other method				
istory of F	lomicide At	tempts	X None	or describe)		
Lugues		t walt lave					
	N notified o			oction taken			
ii a inreati	s made to a	a specific	person, note a	iolion tanen			
Violence:							
Curre	ent X No	☐ Yes	Describe	☐ Person	□ Property		
Past	X No	☐ Yes	Describe	☐ Person	□ Property	7	
Current ri	sk potentia	al X Lo	w ⊡ High C	comments (Denies H	Lintent/plan)





MENTAL STATUS / REVIEW OF SYMPTOMS Patient Appearance Pt Day Contact, Truch, laying hospital hed.
Demeanor ☐ Pleasant
Motor Activity ☐ Hypoactive ☐ Calm ☐ Restless ☐ Hyperactive ☐ Mannerisms
☐ Tics ☐ Tremors ☐ Dyskinesia ☐ Other
Attitude Apathetic Cooperative Friendly Guarded Suspicious Uncooperative
☐ Belligerent ☐ Threatening ☐ Hostile ☐ Other
Speech M Normal Latency M Normal Volume M Normal Fluency Mute Delayed
☐ Soft ☐ Impoverished ☐ Slurred ☐ Incoherent ☐ Loud ☐ Pressured ☐ Excessive
CI Other
Mood Stated, Sad
Affect Apathetic Interested Bright Anxious
Reactivity 🙇 Normal 🗅 Decreased 🗅 Increased
Range M Normal Decreased Increased
Appropriateness to mood/situation Yes O No Describe if No
Perceptions
Hallucinations O No X Yes If Yes mark as indicated
☐ Auditory ☐ Visual ☐ Olfactory ☐ Gustatory ☐ Tactile illusions ☐ Distortions
Thought Pattern Slowed Normal Coherent Circumstantial Blocked
☐ Racing ☐ Loose Association ☐ Derailing ☐ Word Salad ☐ Incoherent
☐ Flight of Ideas ☐ Depersonalization ☐ Derealization
☐ Command (describe content)
SIGNATURE/DEGREE/TITLE DATE/TIME 1008/10 16:11000
CN9199 Page 9 of 17





SINGLE PATIENT ASSESSMENT OF DATA BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

MENTAL STATUS / REVIEW OF SYMPTOMS (continued)

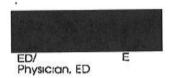
Insight ☐ Intact ☑ Impaired ☐ Describe if impaired ☐ Operated ☐ Describe if impaired ☐ Operated ☐	SIQ)
Thought content Delusions	☐ Ideas of Reference☐ Compulsions
Sensorium and Cognitions:	La la establicación
Level of Consciousness 🔀 Alert 🗆 Fluctuating 🗀 Hyperalert 🗀 Drowsy	☐ Lethargic
Orientation: X Date X Person X Place	
Disorientation: □	
Recent Memory A Intact I Impaned	npaired
Attention Mintact Impaired Concentration Intact In	mpaired
Cognitive Status:	
Evidence of Cognitive Deficits: Yes ONO	
If yes, or if Older than 55 complete FOLSTEIN MINI MENTAL STATE ON PAGE	S 13 & 14.
Additional Symptom Review:	
Sleep	
Appetite	
Energy No Change or Describe	
Manic Symptoms Mo Change or Describe	

SIGNATURE/DEGREE/TITLE

CN9199

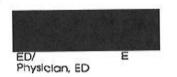
DATE/TIME 10/08/10 6:12000

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CLINICAL:	SUMMARY/IMPR	RESSION VH.	Ptis 5540 male BIBA20 1 blood pressure
Patient	⊠ is not) is	at acute risk to self
Patient	∭ is not	O is	at acute risk to others
Patient	X is not	O is	in need of psychiatric hospitalization.
CD-9 Cod	O.09 Axis		DCI//UM/AS
	799 9 Axis	ı	Defened
7/7/	DDX Axis Axis Axis	in Curl	CMI, Trach, hypokalamia, HTN, gastritis, hyperlipidamia, hy motoractacidents/202 causing inability movelagyans ese Current M-GAF 40 Highest M-GAF in past year unknown (Modified Global Assessment Functioning)
Disposition	notivated for treatn		Ambien, Start Luncita ang
Referral to	protective agency	☐ Yes	χνο α DCF α DSS
Patient's re	adıness for educa	tion is imp	pacted by (mark all that apply)
X No impa ☐ Motivation ☐ Actions t		tate	's beliefs and values
PHYSICIAI	N CASE REVIEW	(check	appropriate box, at least one box must be checked)
□ I have ev	valuated this patie	nt includin	ng risk assessment and concur with the plan for the patient Date
And/or			
have re	viewed this evaluated plan	ation with	Juding risk assessment and he/she is in agreement with
SIGNATUF	RE/DEGREE/TITL		DATE/TIME 10/28/12. 6:18/01
CN9474			Page 11 of 17





SINGLE PATIENT ASSESSMENT OF DATA BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

PHYSICIAN COMPONENT

SUMMARY OF INTERVIEW The Care in Treviewed & Chickian and pe in Seen
Brief the , gl. in a 55 year old Camanan male sent from
Refer of an Chy the supertace, had an hallowindling experience.
of reing his friend gold of the chan willing well- to
Luis on Vist. A. can thing a nop. Just. be for thout
the hear hear howing Their hallowing Experience offer the
part weak He was Experting Visit by his frimes the care
pl- ha been in a trotor eyel Herriant, in Augente
This year, He lost. movements in his copper starm, and
lags the is in Rahal and has grangeries some morecons-
che capper arm and log the is best michan the is
on eymbotter and 79. the liver - American Attentive course of
week all her been having harluci-ting Experience, when
he water up, but realising it is not made when
afracey awake . He is in thocking the
before this wir live the who have impage control
to for The writing the wine to the Design
RECOMMENDATIONS AND PLAN
readized the of paraplage ESRD on
charges HTN Haypoleplane V. + B12 defice
The account his back with Transforting proper through went. He
Le Coule with production of the first of the
on the F State part who is aware of his houthour try 5x persone
But the first for the first section of the first
Recommend with the has been superior and the lease
Die Ambien on the cleme of a court of thought observed
if is known to There is no concern of Thought alringer
Experience Re Metales on Man inches delerum
Try hunerte 2 mg francisky - HTM. ESRD, Hypelip dome
the offen slup.
I have reviewed the preceeding Clinician Assessment including Risk Management and agree with contents
MD / APRN DATE/TIME 10/28/12
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Result date:

28 October 2012 18:22 EDT

Result status:

Auth (Verified)

Addendum *ED



Attachments: None

Medical Decision Making

Notes:seen by BH; recomend stopping Amibient; starting lunesta 2mg. Seen and treated by MD, Maria O'rouke and medically cleared; stable for dsicharge.

Psychiatrist Note Transcribed

Single Patient Assessment of Data Behavioral Health of Waterbury Hospital Physician Component

Summary of Interview: The case was reviewed with clinician and pt seen.

Briefly the pt is a 55 yo Caucasian male sent from the friends [illegible] seeing him on a visit. He was taking a nap just before that. He has been having this hallucinatory experience for the past week. He was expecting visits by his friends today.

Pt has been in a motorcycle accident in August this year. He lost movement in his upper arms and legs. He is in Rehab and has regained some movement in arms and legs. He is bed ridden. He is on Cymbalta and Ambien. Ambien started couple of weeks. He has been having hallucinatory experiences when he wakes up but realizes its not real when fully awake. He has a tracheostomy.

Pt has history of alcohol abuse, opiate use before this incident. He [illegible] impulse control disorder. Pt has been in treatment for Major Depressive Disorder. Medical history of paraplegia., ESRD [end stage renal disease] on dialysis, HTN [hypertension], hypokalemia, Vit[amin] B12 deficiency, [illegible]. Pt appears stated age, lying in bed on his back with tracheostomy attached to vent[ilator]. He is alert and oriented x 3. Calm, cooperative, articulate. He is aware of his hallucinatory experiences. He denies feeling depressed, denies S[uicidal]/H[omicidal] ideation. There is not evidence of a thought disorder.

A/P: Delerium NOS
R/o metabolic or medical causes of delirium
[illegible] HTN, ESRD, hyperlipidemia

Plan: Pt is assessed to be safe [illegible] Recommend: D/C Ambien as it is known to cause delirious experiences. Try Lunesta 2 mg HS for sleep.